Maternal Infant Health Program
Summary of Recommended Stratification Criteria, Interventions, Measures by Domain and Associated Data Sources
05-15-06

(refer to last page for glossary of abbreviations/acronyms)

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
(1) Smoking/Tobacco Use	No tobacco use. .	**No/Low risk**: **Moderate risk**: Smoking one pack per day or less *or* quit smoking since becoming pregnant.	**No/low risk interventions:** All women (regardless of risk status) given information on the effects of tobacco use/second hand smoke during pregnancy and infancy. Information will also be provided regarding smoking cessation programs in the community that partners could attend. Moderate risk/quit smoking during pregnancy interventions: Contact client by phone at regular intervals (minimum of 1-2 times) throughout pregnancy. Offer motivational support and education; provide and information about health plan (for managed care), community, or MDCH quit line, as needed. Communicate client's quit status to OB and (if managed care) to health plan (fax care plan to OB office and to designated plan contact or phone office and plan); request acknowledgement; document communication in client record. Moderate risk/less than 1 pack/day interventions: Refer client to health plan smoking cessation program	Medicaid beneficiaries who screen positive for tobacco use will stop or decrease tobacco use	Measure 1: *% of pregnant Medicaid beneficiaries who use tobacco* Numerator: number of Medicaid deliveries where mother used tobacco Denominator: total number of Medicaid deliveries ********** Measure 2: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 3: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco and who receive one or more MIHP tobacco domain interventions* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco and who receive one or more MIHP tobacco domain interventions Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco ********** Measure 4:	Medicaid claims, Vital Records Medicaid claims, MIHP screen WIC, Vital Records, MIHP screen, ^^MIHP discharge summary

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			(managed care), community, or MDCH quit line for 5A intervention. Communicate client's tobacco use status to OB and (if managed care) to health plan (fax care plan to OB office and to designated plan contact or telephone office and plan); request acknowledgement; document referral and communication in client record. Follow-up with client: If ready to change and participating in cessation program, follow up by phone every 4-6 weeks throughout pregnancy; document. If unready to change, increase frequency of follow-up to every 2-4 weeks; assess smoking and readiness status; ensure that client and OB provider know how to obtain cessation services if client becomes ready; document. Continue to communicate with OB provider or plan, as necessary; document all communication.		*% of pregnant Medicaid beneficiaries with a complete MIHP screen who and who use tobacco and who complete a 5A tobacco cessation program* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco and who complete a 5A tobacco cessation program Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use tobacco ********** Measure 5: *% of pregnant Medicaid beneficiaries who receive one or more MIHP tobacco domain interventions and who quit smoking during pregnancy* Numerator: number of pregnant Medicaid beneficiaries who use tobacco and who receive one or more MIHP tobacco domain interventions and who quit smoking by the date of delivery Denominator: number of pregnant Medicaid beneficiaries who use tobacco and who receive one or more MIHP tobacco domain interventions ********** Measure 6: *% of pregnant Medicaid beneficiaries who receive one or more MIHP tobacco domain interventions and who decrease smoking during pregnancy* Numerator: number of pregnant Medicaid beneficiaries who use tobacco and who receive one or more MIHP tobacco domain interventions and who decrease smoking by the date of delivery	Medicaid claims, MIHP screen, Vital Records, ^^MIHP discharge summary Medicaid claims, ^^MIHP discharge summary Medicaid claims, ^^MIHP discharge summary
		High risk: Smoking more than one pack per day.	High risk interventions: Perform all interventions for moderate risk/less than 1 pack/day and: If client remains unready to			

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			change, refer for additional counseling in the community and/or educate client and coordinate with PCP or OB provider to consider initiation of nicotine replacement therapy (NRT), which should be considered for all women in this group who are unwilling to quit. Document communication and NRT status.		Denominator: number of pregnant Medicaid beneficiaries who use tobacco <u>and</u> who receive one or more MIHP tobacco domain interventions	
(2)Prenatal Care	In care and no access issues identified. Care established by 14 weeks.	**<u>Low</u>**: In care at the time of assessment, but: • began care at or beyond 14 weeks gestation, <u>or</u> • access issues identified.	**<u>All women (regardless of risk status) given transportation information</u>** <u>Low risk</u>: • Coordinate with OB provider and/or health plan. • Phone support PRN to ensure appointments are scheduled and kept.	Pregnant Medicaid beneficiaries will enter prenatal care no later than 14 weeks gestation Medicaid beneficiaries will have a Kotelchuck Index[1] = 80-109%	Measure 7: ***% of Medicaid deliveries where mother entered prenatal care by the end of 14 weeks gestation*** <u>Numerator</u>: number of Medicaid deliveries where mother entered prenatal care by last day of 14th week gestation <u>Denominator</u>: total number of Medicaid deliveries (Note: this is a population-based rate) ********** Measure 8: ***% of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who entered prenatal care by the end of 14 weeks***	Medicaid claims (HEDIS methodology minus continuous enrollment adjusting for week 14) Medicaid claims

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
		High: No care established beyond 14 weeks.	High risk: • Coordinate with OB provider and/or health plan. • Schedule appointment; provide phone support prn to ensure appointments kept. • One counseling session to cover importance of care and basic pregnancy health issues.		***gestation*** Numerator: number of pregnant Medicaid beneficiaries with a completed MIPH screen and who entered prenatal care by last day of 14th week gestation Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 9: ***% of pregnant Medicaid beneficiaries with a completed MIHP screen and one or more MIHP prenatal care domain interventions who entered prenatal care by the end of 14 weeks gestation*** Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and one or more MIHP prenatal care domain interventions and who entered prenatal care by last day of 14th week gestation Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and one or more MIHP prenatal care domain interventions ********** Measure 10: *% of Medicaid deliveries with Kotelchuck (APNCU) Index < 50%* Numerator: number of Medicaid deliveries with Kotelchuck Index < 50% Denominator: total number of Medicaid deliveries **********	Medicaid claims (HEDIS codes/+) Medicaid claims, Vital Records

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
					Measure 11: *% of Medicaid deliveries with Kotelchuck (APNCU) Index 50-79%* Numerator: number of Medicaid deliveries with Kotelchuck Index 50-79% Denominator: total number of Medicaid deliveries ********** Measure 12: *% of Medicaid deliveries with Kotelchuck (APNCU) Index 80-109%* Numerator: number of Medicaid deliveries with Kotelchuck Index 80-109% Denominator: total number of Medicaid deliveries ********** Measure 13: *% of Medicaid deliveries with Kotelchuck (APNCU) Index ≥ 110%* Numerator: number of Medicaid deliveries with Kotelchuck Index ≥ 110% Denominator: total number of Medicaid deliveries ********** Measure 14: *% of Medicaid deliveries with Kotelchuck (APNCU) Index unknown* Numerator: number of Medicaid deliveries with Kotelchuck Index unknown Denominator: total number of Medicaid deliveries ********** (Note: total of numerators for measures 4-8 = total number of Medicaid deliveries)	Medicaid claims, Vital Records Medicaid claims, Vital Records Medicaid claims, Vital Records Medicaid claims, Vital Records

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(3) Nutrition	Client enrolled in WIC.	**Low**: Not enrolled in WIC and BMI within normal limits.	**All women (regardless of risk status) given prenatal vitamin information emphasizing the importance of PN vitamins during preconception and breastfeeding information tailored to level of interest and community resources.** Low risk: • Coordinate with the OB provider and/or health plan. • Refer to/enroll client in WIC. • Initiate 1-2 contacts to discuss community resources and/or nutritional information, prn. • Phone follow-up x 2.	Pregnant Medicaid beneficiaries will enroll in WIC during the first trimester Medicaid beneficiaries will breastfeed	Measure 15: *% of pregnant Medicaid beneficiaries enrolled in WIC* Numerator: number of pregnant Medicaid beneficiaries enrolled in WIC Denominator: total number of Medicaid deliveries ********** Measure 16: *% of pregnant Medicaid beneficiaries who enroll in WIC during the first trimester* Numerator: number of pregnant Medicaid beneficiaries who enroll in WIC by last day of 1st trimester Denominator: total number of Medicaid deliveries ********** Measure 17: *% of Medicaid beneficiaries with a live birth who breastfeed* Numerator: number of Medicaid deliveries resulting in a live birth where mother breastfed Denominator: number of Medicaid deliveries resulting a live birth ********** Measure 18: *% of Medicaid beneficiaries with a live birth and who receive one or more MIHP nutrition domain interventions and who breastfeed* Numerator: number of Medicaid deliveries resulting in a live birth where mother received one or more MIHP nutrition domain interventions and where mother breastfed	WIC, Medicaid claims WIC, Medicaid claims WIC, Vital Records WIC, Medicaid claims

		High: Inadequate or inappropriate weight gain or low/high BMI	High risk:
			• Coordinate with the OB provider and/or health plan.
			• Assess readiness to change.
			  • If ready to change, arrange 2-4 sessions for high-risk nutritional counseling.
			  • If unready to change, contact 2-3 times to address readiness issues and then bi-weekly phone calls x 4 for reassessment.
			• If client becomes ready to change, arrange for 2-4 sessions for high-risk			

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
			nutritional counseling.		Denominator: number of Medicaid deliveries resulting in a live birth where mother received one or more MIHP nutrition domain interventions ********** Measure 19: *% of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> one or more MIHP nutrition domain interventions <u>and</u> who are enrolled in WIC* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> one or more MIHP nutrition domain interventions <u>and</u> who are enrolled in WIC Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> one or more nutrition domain interventions ********** Measure 20: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and one or more MIHP nutrition domain interventions and who enroll in WIC during the first trimester* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> one or more MIHP nutrition domain interventions <u>and</u> who are enrolled in WIC by last day of 1st trimester Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and one or more MIHP nutrition domain interventions ********** Measure 21: *% of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who screen at high risk in the nutrition domain <u>and</u> who*	WIC, Medicaid claims WIC, Medicaid claims ^^MIHP discharge summary Medicaid claims

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
					receive one or more MIHP nutritional interventions Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen at high risk in nutrition domain and who receive one or more MIHP nutrition interventions Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen at high risk in nutrition domain	
(4) Gestational Interval	Wanted/planned pregnancy and **XX** interval.	**Low***:* Client chose to become pregnant but has a short inter-pregnancy interval.	**All women (regardless of risk status) given family planning information and information regarding ideal inter-pregnancy interval.** Low risk: • Coordinate efforts with OB provider and/or health plan. • Provide educational counseling and materials regarding risk of short inter-pregnancy interval. • Review signs of pre-term labor. • Contact client bi-weekly beginning at 24-26 weeks to review signs of pre-term labor.	Medicaid beneficiaries' pregnancies will be wanted Medicaid births will occur within an inter-pregnancy interval no shorter than 18 months	Measure 22: *% of Medicaid births with an inter-pregnancy interval of < 18 months* Numerator: number of Medicaid deliveries with inter-pregnancy interval of < 18 months Denominator: number of Medicaid deliveries ********** Measure 23: *% of Medicaid births with an inter-pregnancy interval of ≥ 18 months* Calculation = 100% - (measure 42) ********** Measure 24: *% of pregnant Medicaid beneficiaries receiving with an inter-pregnancy interval of < 18 months who were Medicaid eligible during previous pregnancy and who received MIHP screening during the previous*	Medicaid claims; Vital Records Calculation only Medicaid claims; Vital Records

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
		High: Client did not want to become pregnant.	High risk: • Coordinate efforts with OB provider and/or health plan. • Provide a minimum of two educational/counseling sessions. • At 36 weeks, review and document client's contraceptive plan. • Contact client 2-4 weeks postpartum to assess maternal-infant bonding and review contraceptive plan. • If short inter-preg. interval present, contact client bi-weekly beginning at 24-26 weeks gestation to review signs of pre-term labor		*pregnancy* Numerator: number of pregnant Medicaid beneficiaries with inter-pregnancy interval < 18 months and who were Medicaid eligible during previous pregnancy and who received MIHP screening during previous pregnancy Denominator: number of pregnant Medicaid beneficiaries with inter-pregnancy interval < 18 months and who were Medicaid eligible during previous pregnancy ********** Measure 25: *% of pregnant Medicaid beneficiaries receiving MIHP services with an inter-pregnancy interval ≥ 18 months and who received MIHP services during the previous pregnancy* Calculation: 100% - (measure 44) ********** Measure 26: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who report wanting their current pregnancy* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who report wanting their current pregnancy Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 27: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who have a contraceptive plan* Numerator: number of pregnant Medicaid	Calculation only MIHP screen ^^MIHP discharge summary

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
					beneficiaries with a completed MIHP screen and who have a contraceptive plan Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen	
(5) Transportation Needs	No transportation issues identified.	**Low**: Access to transportation the only identified risk.	**All women given information regarding transportation services.** Low risk: • Coordinate with the OB provider and/or health plan. • Refer to transportation services, prn.	Medicaid beneficiaries' transportation needs will be met during pregnancy	Measure 28: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for transportation needs* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for transportation needs Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 29: *% of pregnant Medicaid beneficiaries receiving MIHP services and who screen positive for transportation needs and who receive transportation services* Numerator: number of pregnant Medicaid beneficiaries receiving MIHP services and who screen positive for transportation needs and who receive transportation services Denominator: number of pregnant Medicaid beneficiaries receiving MIHP services and who screen positive for transportation needs ********** Measure 30: *% of pregnant Medicaid beneficiaries receiving transportations services*	MIHP screen ^^MIHP discharge summary Medicaid claims
		High: Transportation identified in addition to one or more other risk factors.	High risk: • Coordinate with the OB provider and/or health plan. • Include transportation access in other interventions.			

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					Numerator: number of pregnant Medicaid beneficiaries receiving transportations services Denominator: number of Medicaid deliveries (Note – population rate)	
(6) Basic Needs	No basic needs identified.	**Low**: Client has stable housing, but other basic needs are at risk (i.e. infrequent food supply concerns, utilities, etc.).	**All women (regardless of risk status) given community specific resource\e information.** Low risk: • Coordinate efforts with OB provider and/or health plan. • Initiate community referrals. • Contact client weekly to bi-weekly until stable, then monthly.	Medicaid beneficiaries' basic needs will be met during pregnancy	Measure 31: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who have basic needs (e.g., housing, food, utilities)* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who have basic needs (e.g., housing, food, utilities) Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen Measure 32: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for basic needs and who receive one or more basic needs domain MIHP interventions* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for basic needs and who receive one or more basic needs domain MIHP interventions Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for basic needs	MIHP screen MIHP screen, ^^MIHP discharge summary
		High: Client's housing unstable and/or food supply threatened.	High risk: • Coordinate efforts with OB provider and/or health plan. • Initiate community referrals. • Contact client weekly until stable, then monthly.			
(7) Physical Safety	Negative screen.	**Low**: Client has been in a previously abusive relationship.	**All women (regardless of risk status) given DV/IPV information and community intervention information.** Low risk: • Coordinate with the OB	Medicaid beneficiaries who screen positive for domestic violence will obtain intervention	Measure 33: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for domestic violence* Numerator: number of pregnant Medicaid beneficiaries with a completed MIPH screen	MIHP screen

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
	.		provider and/or health plan. • Review and discuss personal safety. • Provide client with community-specific intervention information/resources.		and who screen positive for domestic violence Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 34: *% of pregnant Medicaid beneficiaries who screen positive for domestic violence and who are referred for domestic violence intervention* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for domestic violence and who are referred for domestic violence intervention Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for domestic violence ********** Measure 35: *% of pregnant Medicaid beneficiaries who screen positive for domestic violence and who are referred for domestic violence intervention and who receive domestic violence intervention* Numerator: number of pregnant Medicaid beneficiaries who screen positive for domestic violence and who are referred for domestic violence intervention and who receive domestic violence intervention Denominator: number of pregnant Medicaid beneficiaries who screen positive for domestic violence and who are referred for domestic violence intervention	MIHP screen, ^^MIHP discharge summary MIHP screen, ^^MIHP discharge summary (QUESTION – WOULD CLAIMS BE USED HERE, ALSO?)
		High: Client in a current abusive relationship.	High risk: • Coordinate with the OB provider and/or health plan. • Initiate DV intervention referral. • Develop, review, and document personal safety reviewed and emergency plan. • Initiate weekly contact until stable. • Monthly program contact thereafter.			
(8) Chronic Disease	No chronic disease(s) identified.	**Low**: Client understands and adheres to her chronic disease treatment plan or is enrolled in a health plan DM program.	• Coordinate with the OB provider and/or health plan. • If not already enrolled, refer to available health	Pregnant Medicaid beneficiaries with chronic diseases will receive care coordination Pregnant women receiving MIHP services	Measure 36: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who have asthma (or diabetes - repeat this measure for diabetes)*	MIHP screen

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
			plan DM program(s). • Contact client monthly to every trimester to ensure client is stable.	will experienced decreased ED and IP admissions for diabetes and asthma	Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who have asthma (or diabetes) Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen ********** Measure 37: *% of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who screen positive for asthma (or diabetes – repeat this measure for diabetes) <u>and</u> who receive care coordination* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who screen positive for diabetes (<u>or</u> asthma – calculate separately) <u>and</u> who receive care coordination Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who screen positive for asthma (<u>or</u> diabetes – calculate separately) ********** Measures 38-41 *Rates –for pregnant Medicaid beneficiaries with asthma <u>or</u> diabetes:* • *Asthma ED visits* • *Asthma IP admissions* • *Diabetes ED visits* • *Diabetes IP admissions* Numerators (calculated separately): number of pregnant Medicaid beneficiaries with asthma <u>or</u> diabetes (calculated separately) and numbers of asthma (<u>or</u> diabetes) ED visits (also IP – calculated separately) Denominators: number of pregnant Medicaid beneficiaries with asthma <u>or</u> diabetes	MIHP screen, ^^MIHIP discharge summary Medicaid claims (all)
		<u>High</u>: Client does not understand her chronic disease treatment plan, is not adhering to the plan, or has an ED or IP admission in the six months prior to assessment for the identified condition(s).	• Coordinate with the OB provider and/or health plan. • Refer to available health plan DM program(s) and coordinate with DM case management. • If no DM program available, contact client weekly until stable, then bi-weekly to monthly.			

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
					(calculated separately) (Note – these are population-based rates) ********** Measures 42-45: *Rates – for pregnant Medicaid beneficiaries who complete a MIHP screen <u>and</u> who have asthma <u>or</u> diabetes:* • *Asthma ED visits* • *Asthma IP admissions* • *Diabetes ED visits* • *Diabetes IP admissions* Numerators (calculated separately): number of pregnant Medicaid beneficiaries who complete a MIHP screen <u>and</u> who have asthma <u>or</u> diabetes (calculated separately) <u>and</u> numbers of asthma (<u>or</u> diabetes) ED visits (also IP – calculated separately) Denominators: number of pregnant Medicaid beneficiaries who complete a MIHP screen with asthma <u>or</u> diabetes (calculated separately) (Note – these are program rates)	MIHP screen, Medicaid claims
(9) Substance Abuse	No substance use.	**<u>Low</u>:** Client previously or currently in substance abuse treatment.	**<u>All women (regardless of risk status) given basic educational materials regarding substance use and treatment.</u>** <u>Low risk</u>: • Coordinate efforts with OB provider and/or health plan. • Initiate bi-weekly to monthly contact to ensure treatment is successful.	Medicaid beneficiaries who screen positive for alcohol/substance use will stop or decrease alcohol/substances	Measure 46: *% of pregnant Medicaid beneficiaries who use alcohol/substances* Numerator: number of Medicaid deliveries where mother used alcohol or substances <u>Denominator</u>: total number of Medicaid deliveries ********** Measure 47: *% of pregnant Medicaid beneficiaries with a completed MIHP screen <u>and</u> who use alcohol or substances <u>and</u> who receive one or more*	QUESTION – ARE DATA AVAILABLE TO CALCULATE THIS RATE? Medicaid claims, ^^MIHP discharge summary

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		High: Client admits to alcohol and/or substance use.	High risk: • Coordinate efforts with OB provider and/or health plan. • Assess readiness to change. – If client is ready to change, refer for treatment. – If client is unready to change, contact weekly for 4-6 weeks to work on readiness to change.		*MIHP alcohol/substance domain interventions* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use alcohol or substances and who receive one or more MIHP alcohol/substance domain interventions Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use alcohol or substances ********** Measure 48: *% of women receiving MIHP services who screen positive for alcohol/substance use and who enter treatment* Numerator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use alcohol or substances and who enter treatment Denominator: number of pregnant Medicaid beneficiaries with a completed MIHP screen and who use alcohol or substances ********** Measure 49: *% of pregnant Medicaid beneficiaries who receive one or more MIHP alcohol/substance domain interventions and who decrease alcohol or substance use during pregnancy* Numerator: number of pregnant Medicaid beneficiaries who use alcohol or substances and who receive one or more MIHP alcohol/substance domain interventions and who decrease alcohol or substance use by the date of delivery Denominator: number of pregnant Medicaid beneficiaries who use alcohol or substances	MIHP screen, Medicaid claims Medicaid claims, ^^MIHP discharge summary

Core Domain	Negative Screen	Positive Screen/Risk Stratification Level	Intervention(s)	Desired Outcome(s)	Measure(s)	Data Source(s) (^^ denotes currently unavailable)
					and who receive one or more MIHP alcohol/substance domain interventions	
(10) Behavioral Health/Depression	Negative screen for depression.	**Low**: Edinburgh depression tool results in a mild score, or woman is already being treated for depression.	**All women (regardless of risk status) given information regarding signs of perinatal depression and treatment.** Low risk: • Coordinate with the OB provider and/or health plan (with appropriate client consent). • Educate client on the benefits of exercise to treat mood disorders. • Refer for counseling and/or support group. • Initiate monthly contact with client to reassess (Edinburgh) and provide support.	Medicaid beneficiaries who screen positive for depression (during pregnancy or after delivery) will obtain treatment	Measure 50: *% of pregnant Medicaid beneficiaries with a completed MIHP screen and who screen positive for depression* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive for depression Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen ********** Measure 51: *% of pregnant Medicaid beneficiaries screening positive/mild for depression who are referred for treatment* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/mild for depression and who are referred for treatment Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/mild for depression ********** Measure 52: *% of pregnant Medicaid beneficiaries screening positive/moderate for depression who are referred for treatment* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/moderate for depression and who are referred for treatment	Medicaid claims, MIHP screen MIHP screen, ^^MIHP Discharge Summary MIHP screen, ^^MIHP discharge summary
		High: Edinburgh depression tool results in a moderate or severe score.	High risk: • Coordinate with the OB provider and/or health plan. • Educate woman on the benefits of exercise to treat mood disorders. • Refer for and coordinate pharmacological treatment with the OB provider and/or health plan BH provider or CMH (with appropriate client consent).			

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			• Refer for counseling and/or support group. • Initiate weekly contact with client until stable and then bi-weekly to monthly. • Develop and document emergency plan.		Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/moderate for depression ********** Measure 53: *% of pregnant Medicaid beneficiaries screening positive/severe for depression who are referred for treatment* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/severe for depression and who are referred for treatment Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive/severe for depression ********** Measure 54: *% of pregnant Medicaid beneficiaries who screen positive for depression and who are referred for treatment and who receive treatment* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive for depression and who are referred for treatment and who receive treatment Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen and who screen positive for depression and who are referred for treatment ********** Measure 55: *% of Medicaid beneficiaries who complete a depression screen after delivery*	MIHP screen, ^^MIHP discharge summary MIHP screen, ^^MIHP discharge summary, Medicaid claims (behavioral health claims; pharmacy) QUESTION – NEED CLARIFICATION – IS THIS A POPULATION OR PROGRAM

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					Numerator: number of Medicaid beneficiaries who complete a depression screen after delivery Denominator: number of Medicaid beneficiaries who complete a MIHP screen	RATE?

Additional Program Evaluation Measures:				**Desired Outcome(s)**	**Measure(s)**	**Data Source(s) (^^ denotes currently unavailable)**
(11) MIHP Screening				Pregnant Medicaid beneficiaries will receive MIHP screening	Measure 56: *% of pregnant Medicaid beneficiaries who complete a MIHP screen* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen Denominator: total number of Medicaid deliveries (Note: this is a population-based rate) ********** Measure 57: *% of pregnant Medicaid beneficiaries who complete a MIHP screen <u>and</u> who screen positive in one or more domains <u>and</u> who complete a MIHP assessment* Numerator: number of pregnant Medicaid beneficiaries who complete a MIHP screen <u>and</u> who screen positive in one or more domains <u>and</u> who complete a MIHP assessment Denominator: number of pregnant Medicaid beneficiaries who complete a MIHP screen <u>and</u> who screen positive in one or more domains ********** Measure 58: *% of pregnant Medicaid beneficiaries screening positive <u>and</u> who receive MIHP services* Numerator: number of pregnant Medicaid beneficiaries screening positive <u>and</u> who receive MIHP services Denominator: number of pregnant Medicaid beneficiaries screening positive	Medicaid claims and MIHP screen Medicaid claims MIHP screen, Medicaid claims, ^^MIHP discharge summary

(12)MIHP Interventions				Number of MIHP visits will be determined by client risk	Measure 59: *Mean number of MIHP visits for pregnant Medicaid beneficiaries who complete a MIHP screen and who screen at low risk in all domains – also calculate by domain* Numerator: (number of Medicaid beneficiaries who complete a MIHP screen and screen at low risk in all domains) x (number of MIHP visits for these beneficiaries) Denominator: number of Medicaid beneficiaries who complete a MIHP screen and screen at low risk in all domains (Note – also calculate by domain) ********** Measure 60: *Mean number of MIHP visits for pregnant Medicaid beneficiaries who complete a MIHP screen and who screen at high risk in all domains – also calculate by domain* Numerator: (number of Medicaid beneficiaries who complete a MIHP screen and screen at high risk in all domains) x (number of MIHP visits for these beneficiaries) Denominator: number of Medicaid beneficiaries who complete a MIHP screen and screen at high risk in all domains (Note – also calculate by domain)	MIHP screen, ^^MIHP discharge summary MIHP screen, ^^MIHP discharge summary
(13) Client Satisfaction				MIHP clients will be satisfied with the program	Measure 61: *% of Medicaid beneficiaries responding to a post-program survey who report being "satisfied" or "very satisfied" with the MIHP* Numerator: number of Medicaid beneficiaries responding to a post-program survey (to be developed) who report being "satisfied" or "very satisfied" with the MIHP	^^Client survey

					Denominator: number of Medicaid beneficiaries responding to a MIHP post-program survey (Note: survey to be developed; question whether to sub-segment into two groups: those screening negative in all domains and receive basic info only and those screening positive and receiving more intensive program services)	
(14) Provider Satisfaction				MIHP providers will be satisfied with the program	Measure 62: *% of MIHP providers responding to a program survey who report being "satisfied" or "very satisfied" with the MIHP* Numerator: number of MIHP providers responding to a program survey (to be developed) who report being "satisfied" or "very satisfied" with the MIHP Denominator: number of MIHP providers responding to a MIHP program survey	^^Provider survey

Glossary of abbreviations/acronyms:

CMH: Community Mental Health
DM: disease management
DV: domestic violence
ED: emergency department
HEDIS: Health Plan Employer Data and Information Set
IP: inpatient
IPV: intimate partner violence
MIHP: Maternal Infant Health Program
OB: obstetrics
PN: prenatal
PRN: when necessary
WIC: Women, Infants and Children Program

[1] The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses two crucial elements obtained from birth certificate data-when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). The Kotelchuck index classifies the adequacy of initiation as follows: pregnancy months 1 and 2, months 3 and 4, months 5 and 6, and months 7 to 9, with the underlying assumption that the earlier prenatal care begins the better. To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. The expected number of visits is based on the American College of Obstetricians and Gynecologists prenatal care standards for uncomplicated pregnancies and is adjusted for the gestational age when care began and for the gestational age at delivery. A ratio of observed to expected visits is calculated and grouped into four categories-Inadequate (received less than 50% of expected visits), Intermediate (50%-79%), Adequate (80%-109%), and Adequate Plus (110% or more). The final Kotelchuck index measure combines these two dimensions into a single summary score. The profiles define adequate prenatal care as a score of 80% or greater on the Kotelchuck Index, or the sum of the Adequate and Adequate Plus categories. (source: http://scangis.dhec.sc.gov/scannet/defn/birthdefn.htm)